

passant, a human case directly traceable to squirrels has recently occurred. Interesting as all this is from a scientific standpoint, the question naturally arises as to what practical application is to be made of these discoveries. Primarily, it may be said that a focus for plague is being dealt with which, if allowed to continue, will stamp California as an endemic plague center, and it further appears that the squirrel is the animal in which the disease is kept alive to spread to rats and thence to man. The natural deduction is, therefore, that the ground squirrel must be eradicated. This means an extensive propaganda of education to the end that the individual ranch holder will lend his thorough co-operation. This has already been launched by Passed Assistant Surgeon W. C. Rucker, who is in charge of the field work, and bids fair to yield excellent results. An extensive article by him upon this subject appears in the Public Health Reports for August 27th and it should be read by every physician in California. There is no telling how far the infection has spread and what other counties in the state may be harboring the disease in rodent form. We must, therefore, be on the lookout for human or rodent cases and should report to the health authorities the occurrence of suspicious cases in our practice or a high death rate among ground squirrels.

The impression that glycosuria and diabetes are not "rare" or "uncommon," as stated in some text-

DIABETES IN NEW YORK CITY.

books, has in recent years gained a strong hold on the minds of many physicians. While many statistics have been printed concerning the incidence of these conditions, the great variance of the figures have made it difficult to arrive at any accurate conception of the truth. So much so has this been the case that Naunyn, in his book on Diabetes, says that almost any figures desired can be selected from the various estimates, and that only out of courtesy to the authors does he quote any of them. For the most part such statistics are based on hospital and mortality records, and while useful in some directions, it must be realized that they give no information as to the actual incidence of either glycosuria or diabetes in the community at large, for many diabetics never enter a hospital and many die from other diseases.

The recent study of Ballinger (the Archives of Internal Medicine, May, 1909), however, throws some light on this interesting question. His conclusions are based on the records of one of New York's large insurance companies. Between the years 1902 and 1907, 71,729 adults were examined medically by this company. They belonged, naturally, to the better social class, which shows, as is generally recognized, a greater incidence of diabetes than does the poorer class of people. Probably 95% or more of them were men between the ages of 18 and 60, and of course they were practically all on a mixed diet (one containing carbohydrates). The number showing glucose on one or more examinations was 2,043 or 2,840 per 100,000. Of these 681 showed between 1 and 12 per cent, and 1362 less than 1

per cent of sugar. If we consider the presence of 1 or more per cent of sugar in an office specimen of urine, a criterion of the existence of diabetes, the incidence of diabetes per 100,000 of population would be 950. Such a criterion, however, is obviously a very arbitrary one, but not without some justification, as pointed out by Barringer. Experience has shown that persons having 1 per cent or more of sugar on an ordinary diet containing slight or moderate amounts of carbohydrates, are under strong suspicion and probably have diabetes. Moreover, Barringer and Roper have shown that of a group of twenty patients with slight glycosuria, nine or 45 per cent developed diabetes at the end of five years.

Figuring on the basis that 50 per cent of the 1362 cases with less than 1 per cent of sugar in the urine, Barringer finds a total of 1895 per 100,000 of population with diabetes. These figures are nothing short of startling when we consider the statistics of Osler, who says that among 99,000 patients admitted to the medical wards and medical dispensary of the Johns Hopkins Hospital, there were only 226 cases of diabetes or 228 per 100,000 of medical admissions; or the last mortality statistics by the United States Census Bureau, which show between 1901 and 1905 a yearly average of 11.6 deaths from diabetes per 100,000 of population.

From time to time the subject of post-operative lung complications is brought in review before the surgical world.

POST-OPERATIVE PUL- MONARY COMPLICATIONS.

during the past few months a number of noteworthy articles have appeared. Among these, the two most suggestive to the writer are those by Munro in our own land, and by Ranzi, of Vienna. The former deals exclusively with bronchitis and pneumonia, and the latter with lung conditions of an embolic nature. Both papers more or less clearly point the same moral, and that rather a different one from the time honored conception of post-operative chest complications.

It has been the habit for a long time for surgeons to shift the responsibility of these disconcerting contingencies to the shoulders of the anaesthetist. The irritative properties of ether are likewise accused of marring the results of operations that were expected to be successful. The complacent comfort of having these scapegoats of the surgical conscience, is being rudely torn from our all too short list of consoling excuses. The first threat that such an invasion of our vested rights was coming, was seen in the results of operations after local and spinal anaesthesia. As regards the subject at issue, the results were no whit better. Here was food for thought.

The answer to the puzzle seems to be pretty clearly worked out, and necessitates a shifting of the direction of the finger of accusation from the anaesthetist and anaesthetic, to the operator himself. It comes back, as so many other matters come back, to the subject of technic. In other words, with the exception of operations about the mouth and throat,